Complete Summary

GUIDELINE TITLE

Substance abuse treatment for persons with HIV/AIDS.

BIBLIOGRAPHIC SOURCE(S)

Treatment Improvement Protocol (TIP) Series 37 Consensus Panel. Substance abuse treatment for persons with HIV/AIDS. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 2000. (Treatment improvement protocol (TIP) series; no. 37). [546 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Substance use disorders, HIV infections, acquired immunodeficiency syndrome (AIDS)

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Evaluation
Prevention
Risk Assessment
Treatment

CLINICAL SPECIALTY

Preventive Medicine
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To reinforce the creation of a comprehensive, integrated system of care for human immunodeficiency virus (HIV)-infected substance abusers

TARGET POPULATION

HIV/AIDS-infected substance abusers

INTERVENTIONS AND PRACTICES CONSIDERED

Counseling/Education

1. Education to promote adherence to antiretroviral treatment
2. HIV/AIDS education and counseling
3. HIV pre- and posttest counseling.
4. Supportive services: counseling of ill and dying clients and their children; discussing end-of-life health care options with clients
5. Counseling to review treatment options

Evaluation

1. HIV risk assessment and/or assessment of the behaviors associated with HIV transmission.
2. HIV testing and test result notification
3. Thorough medical history
4. HIV/AIDS-directed general physical exam focusing on the skin, the eyes, the mouth, the anogenital region, the nervous system, the lymphatic system, and patient weight and temperature
5. Chest x-ray and laboratory studies, including HIV ribonucleic acid (RNA) (or viral load), CD4+ T cell counts, blood counts, screening chemistries, syphilis, toxoplasmosis, purified protein derivative, hepatitis A, B, and C viruses

Treatment

1. Integrated care

2. Modified and expanded primary care to ideally include a multidisciplinary staff, with social workers, physicians, physicians-in-training, nurses, counselors, and a case manager
3. Pain management: local measures (rest, heat, ice, analgesic rubs) as a first line of pain treatment when appropriate; a systematic pharmacologic approach (initially, over-the-counter medications such as aspirin, acetaminophen, and nonsteroidal anti-inflammatory agents should be used, with dosages increased as needed); narcotic analgesia; consultation with pain management specialists; the World Health Organization's (WHO's) "cancer pain analgesic ladder"
4. Indwelling intravenous line for infusion therapy
5. Participation in clinical trials
6. Alternative or complementary therapies; for example, acupuncture, meditation, and vitamin and herbal dietary supplements
7. Vaccinations, including: Pneumococcal vaccination; Vaccination against Haemophilus influenzae type B and Hepatitis A
8. Sexually transmitted disease treatment
9. Interventions that address the causes of inadequate food consumption, such as nutritional supplements

Mental Health Evaluation and Treatment

1. Referral to mental health services
2. Setting realistic treatment goals that correspond to the client's functional capacities
3. Cultural compatibility between therapists and clients
4. Psychiatric diagnostic evaluation
5. Assessment of suicidality
6. Pharmacologic approaches to treat psychiatric conditions
7. Counseling to help the HIV-infected substance abuser maintain health, achieve recovery from the substance abuse, and attain the best possible level of psychological functioning
8. Support groups

Primary and Secondary HIV Prevention

1. Risk assessment protocols
2. Sexual practices history
3. Discussion of risk behaviors in language that is culturally appropriate, clear, and understandable
4. HIV sexual risk reduction programs
5. Intravenous drug use risk reduction programs, including syringe exchange programs
6. Infection control policy and practice in substance abuse treatment programs
7. Postexposure prophylaxis in occupational settings
8. HIV prevention counseling

Integrating Treatment Services

1. Case management model, including social services as a core part of the treatment plan, cross-training all providers in the requirements of the other treatment centers, and facilitating eligibility determinations

2. Abstinence-oriented approaches to substance abuse treatment versus public health-oriented approaches
3. Counselor familiarity with local AIDS Service Organizations and substance abuse treatment services
4. Network of care coordination: issues of confidentiality, "consent" and "informed consent."

MAJOR OUTCOMES CONSIDERED

- Access to care
- Integration of treatment services
- Adherence to treatment
- Morbidity and mortality

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

All Treatment Improvement Protocols (TIPs) are produced after a major literature search followed by a meta-analysis by skilled professionals on the contractor's staff. Then the research-based evidence is combined with whatever field-based experience is shared at the consensus panel.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

After selecting a topic for a Treatment Improvement Protocol (TIP), the Center for Substance Abuse Treatment invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A large and diverse group of field experts closely reviewed the draft document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations supported by research literature or legislation are followed by a (1); clinically based recommendations are marked (2).

Medical Treatment

- Treating HIV/AIDS is extremely complex. It is important that the medical care team have experience working with substance-abusing clients because the combination of substance abuse and HIV/AIDS poses special challenges. Integrated care is the best treatment option, and medical practitioners who work with substance abuse treatment centers should be experienced in treating HIV/AIDS patients. (2)
- Primary care staff serving HIV-infected patients with substance abuse disorders should understand and be responsive to patients' needs, potential for relapse, and cultural variations. Primary care models that are incorporated as part of substance abuse treatment programs should be evaluated to

identify how they can be modified and expanded to address the special needs of the HIV-infected substance abuse disorder population. (2)

- Adherence to antiretroviral treatment means that the client must follow a prescribed and often complicated treatment regimen. Adherence should be maintained because nonadherence can lead to the rapid development of drug resistance. (1)
- One means to encourage adherence is to educate clients and their significant others about HIV/AIDS treatment. (2)
- Ideally, all treatment programs should be capable of conducting HIV risk assessments and providing basic HIV/AIDS education and counseling to clients. In addition, all programs should provide access to HIV testing and pre- and posttest counseling. If such services cannot be provided, linkages should be established with other agencies that can provide these services. When clients are sent from substance abuse treatment programs to referral sites for primary medical care, a communications system should be in place to ensure that appointments are kept, that information about clients' medical care is sent back to the program, and that the communications system complies with Federal and State confidentiality requirements. (2)
- Optimally, primary care should be multidisciplinary, with social workers, physicians, physicians-in-training, nurses, and counselors included among the treatment staff. A case manager may be helpful in facilitating communication among treatment personnel. Existing primary care models should be evaluated to identify how they can be modified and expanded to address the special needs of HIV-infected substance abusers. (2)
- Testing for HIV is a crucial first step in engaging the HIV-infected substance abuser. A low threshold for testing should exist when one assesses the client's level of risk for HIV. This can be determined by the following: if the client has engaged in risky behaviors; if the client has ever had a sexually transmitted disease; if the client has a history of sharing drug injection equipment; or if the client is presenting with any of a number of symptoms that might indicate recent infection with HIV or early symptomatic infection. (2)
- Medical care for HIV-infected patients will vary, depending on the stage of infection, but all patients should receive a minimum level of evaluation and followup. An assessment of the behaviors associated with HIV transmission is an important part of the initial assessment. (2)
- A thorough medical history is an important step to help the clinician proceed to clinical evaluation and formulate a treatment plan. Although HIV/AIDS and its complications may involve nearly every organ, the HIV/AIDS-directed general physical exam should focus on the skin, the eyes, the mouth, the anogenital region, the nervous system, the lymphatic system, and patient weight and temperature. Knowledge of a patient's immune status may also direct the clinician toward screening other areas. (2)
- Before starting antiretroviral therapy in any patient, laboratory studies should be done and may include HIV ribonucleic acid (RNA) (or viral load), CD4+ T cell counts, blood counts, screening chemistries, syphilis, toxoplasmosis, purified protein derivative, hepatitis A, B, and C viruses, and chest x-ray. (2)
- The decision to begin antiretroviral therapy in the asymptomatic patient is difficult and often involves multiple visits to review treatment options. The factors that must be considered include patient willingness to begin therapy and remain adherent, the degree of immunodeficiency, the risk of disease progression as determined by plasma HIV RNA, the risks of side effects, the ongoing treatment of other medical conditions, and barriers to care, such as lack of insurance and unstable housing. (2)

- Criteria for changing therapy include:
    1. Suboptimal initial reduction in HIV RNA level
    2. Reappearance of viremia after suppression to undetectable levels
    3. Persistent and progressive decline in CD4+ T cells
    4. Development of intolerable side effects
- The client's inability to adhere to a treatment regimen. (In all cases, the clinician must determine whether the treatment failure is due to imperfect adherence [because of toxicity or patient disinterest], altered absorption or metabolism of one or more drugs in a multidrug pharmacokinetics, or viral resistance to one or more agents. When the decision to change therapy is based on HIV RNA, a second viral load test is needed before any decision can be made.) (1)
- In general, it is preferable to change all of the drugs used in failing combination, except in those instances when viral loads are undetectable and a side effect can be traced to a specific medication. In some cases in which the viral load is not suppressed completely, it may be best to continue the present regimen if it has been partially effective and the patient's options are limited. (1)
- Managing acute and chronic pain in HIV-infected patients with substance abuse disorders can be a challenging clinical problem. As with all patients in pain, the provider's primary goal is to maximize comfort while minimizing side effects. Local measures (rest, heat, ice, analgesic rubs) should be used as a first line of pain treatment when appropriate. If these measures fail to relieve pain, a systematic pharmacologic approach is recommended. Should these medications prove inadequate for pain relief, narcotic analgesia may be necessary. (1)
- The treatment plan and the reason for using narcotics for pain control must be clear to both provider and patient. It is important not only that the patient knows that his pain is taken seriously but also that narcotic use will not be extended beyond a limited period required for analgesia. Pain management specialists should be consulted as needed to examine alternative management strategies. Because HIV/AIDS patients often have pain problems similar to those of cancer patients, the World Health Organization's "cancer pain analgesic ladder" is useful as a starting point for managing pain in HIV-infected persons. (1)
- Setting clear limits and devising a consistent treatment plan can help to reduce the risk of medication abuse by patients. The following strategies are recommended: designate one care provider to dispense prescriptions for controlled drugs, dispense limited amounts of controlled drugs (e.g., 1-week supply or less), and advise patients that lost or stolen prescriptions will not be replaced. (2)
- Clients who are symptomatic with AIDS frequently are prescribed narcotic analgesics and may also have an indwelling intravenous line for infusion therapy. Injection drug users are at very high risk of using this indwelling intravenous line to administer heroin, cocaine, and other drugs of abuse. It is therefore essential that clients with such lines be cared for in residential settings where adequate monitoring and support can be provided. (2)
- Ongoing efforts are needed to educate patients about the importance of clinical trials and to alleviate their long-standing suspicion of the medical profession. Specific efforts should be made to include more substance abuse clients, women, and minorities in HIV clinical trials. All of these groups currently are underrepresented. To avoid a conflict of interest, it is

recommended that, as far as possible, the clinician responsible for the clinical trial not be the patient's primary care provider. (2)

- Care providers must be aware that HIV-infected patients may be using alternative or complementary therapies; for example, acupuncture, meditation, and vitamin and herbal dietary supplements. However, patients need not be discouraged from trying a therapy unless it is known to be harmful. Clinicians have a responsibility to discover, in a nonjudgmental manner, what alternative or unapproved therapies patients are using and then to obtain as much information as possible about these therapies. Clinicians should specifically ask about unsupervised antibiotic use because it can complicate the diagnosis and treatment of bacterial infections in HIV-infected substance abuse clients. (1)
- The Consensus Panel supports the Center for Disease Control´s recommendation that HIV infection be considered an indication for pneumococcal vaccination because of the markedly increased risk of pneumococcal pneumonia among HIV-infected clients. The effectiveness of this vaccine in clients with severely weakened immune systems is questionable, but it has been found to provide moderate immunity when administered in the earlier stages of HIV infection. Vaccination against H. influenzae type B should also be considered because HIV-infected individuals, particularly injection drug users, are at increased risk for H. influenzae pneumonia. Hepatitis A vaccine should be administered when necessary because most injection drug users are hepatitis C positive and the Center for Disease Control recommends hepatitis A vaccine in all hepatitis C-positive individuals. (1)
- Primary care providers should be aware that, in general, the incidence of gynecological disorders is likely to be higher among female substance abusers than among non-substance-abusing women. Some disorders such as sexually transmitted diseases result indirectly from substance abuse, while others may result from lifestyle factors that influence the overall health status of women, such as the lack of regular medical care. (1)
- Treatment personnel must be aware of the special nutritional needs of HIV-infected substance abusers. Staff should be familiar with guidelines concerning nutritional supplements and with interventions to address the causes of inadequate food consumption. (2)

Mental Health Treatment

- Individuals with substance abuse disorders, whether or not they are HIV infected, are subject to higher rates of mental disorders than the rest of the population. Counselors working with HIV-infected substance abusers should be aware of the variety of both HIV- and substance-induced psychiatric symptoms. It is also important to recognize that psychiatric symptoms may be caused by substance abuse, HIV/AIDS, or the medications used to treat HIV/AIDS, as well as by preexisting psychiatric disorders. (1)
- Treatment programs that do not have the resources to adequately assess and treat mental illness should be closely linked to mental health services to which clients can be referred. Open lines of communication will enable personnel in both locations to be informed about a client's treatment program. Treatment staff should maintain contact with the client and continue treatment during and after the psychiatric referral. (2)

- Communication between medical and counseling staffs is important to ensure that cognitively impaired clients are not perceived as deceitful or manipulative. Care providers must keep in mind that cognitively impaired clients' nonadherence to treatment may be a result of the impairment and not caused by denial, resistance, or unwillingness to accept care. (2)
- It is essential to set realistic treatment goals that correspond to the client's functional capacities. (2)
- Therapeutic interventions must be sensitive to the culture and ethnicity of the client population. Whenever possible, therapists and support group leaders should share the culture of their clients and should speak the same language. Cultural compatibility between therapists and clients is important in creating an atmosphere of trust where sensitive issues, such as family support and group mores, can be addressed. (2)
- Assessment and diagnosis of mental illness in HIV-infected substance-abusing clients is a daunting challenge because of these clients' complex problems. Therefore, it is important to evaluate clients' behavior in context (e.g., acute depression is common in people who have just learned they are HIV positive). (1)
- Standard pharmacologic approaches may be used to treat psychiatric disorders in HIV-infected substance abusers, with some specific considerations. Without exception, a medical and psychiatric diagnostic evaluation should always be carried out before medication is provided. (1)
- When prescribing medications for HIV-infected substance abusers, physicians should use a graduated approach that increases the level and type of medication slowly, one step at a time. Low doses of medications that are safer and less likely to be abused should be tried first, and higher doses or less safe agents used only if the initial approach is ineffective. (1)
- With highly active antiretroviral therapy the physician must be aware of potential drug interactions that can increase the toxicity of medications or reduce their levels in the patient's blood, resulting in suboptimal therapy and the development of resistance. The mental health counselor should be familiar with the symptoms that could indicate that a client is experiencing a drug interaction. (1)
- HIV-infected individuals may be more sensitive to prescription medications as well as to drugs of abuse. When prescribing, clinicians should attempt to use the lowest effective dose to minimize side effects. With clients symptomatic with AIDS, it may be wise to begin with very low doses, of the magnitude generally associated with geriatric patients. (1)
- Substance abusers are at increased risk of suicide. HIV-infected individuals may also be at risk of suicide, especially if they are suffering from a mood disorder. Medication should be dispensed in small amounts until a client's level of responsibility can be fully assessed. Prescribers should be aware that some medications such as tricyclic antidepressants (like amitriptyline [Elavil]) are especially likely to be lethal in overdose. (2)
- Counseling is an important part of treatment for all substance abusers, including those with comorbid psychiatric disorders. The goal of counseling is to help the HIV-infected substance abuser maintain health, achieve recovery from the substance abuse, and attain the best possible level of psychological functioning. (2)
- If a client is not acutely suicidal but wants to talk about suicide, the counselor should maintain interest, allow the client to discuss his feelings, assess the severity of the client's suicidality, and obtain help if needed. The counselor

should not minimize the client's experiences because talking openly about suicide decreases isolation, fear, and tension. (2)
- Support groups fulfill a wide range of needs. Substance abuse treatment programs should actively refer clients to appropriate outside support groups where their specific needs can be met. (2)

Primary and Secondary HIV Prevention

- For HIV-infected clients in substance abuse treatment, there must be a comprehensive approach to treatment that includes three goals: living substance free and sober, slowing or halting the progression of HIV/AIDS, and reducing HIV risk-taking behavior. (2)
- Numerous risk assessment protocols exist and may be used with a minimum of training and familiarity. The goal of the HIV/AIDS risk assessment should be to identify behaviors that may place the client at risk for HIV infection. (2)
- A comprehensive sexual practices history is important and should be taken early in counseling, although not necessarily at the first session. Clients must be reassured of the confidentiality of the information they provide. (2)
- Counselors should address the full range of potential risk behaviors in their history taking, including both syringe sharing and unsafe sex. They must take into account a wide range of sexual orientations, including those of homosexual, bisexual, heterosexual, and transgender clients. Condom use and safer sex practices must be a special focus of the assessment. Counselors need to know what the client believes about HIV/AIDS, including any information the client received from other treatment professionals. (2)
- In promoting risk reduction, the alcohol and drug counselor should help the client understand the need for change, provide psychological support for behavior change, and assist the client in developing the appropriate skills to sustain the behavior change. (2)
- Discussion of risk behaviors should take place in language that is culturally appropriate, clear, and understandable. (2)
- HIV sexual risk reduction programs should be integrated into substance abuse treatment programs. Sexual risk reduction programs should provide clients with basic information about safer sex practices, as well as an array of alternative strategies and choices that are client controlled. (2)
- Intravenous drug user risk reduction is best approached in a step-wise fashion; for example, abstinence is the best step, no syringe use is the second best step, not sharing syringes is the third best step, using only clean syringes is the fourth best step, and so on. (2)
- Federal law currently prohibits using Federal funds for syringe exchange programs. (1)
- The AIDS pandemic poses a number of challenges for infection control policy and practice in substance abuse treatment programs. Treatment programs should apply the same universal precautions that exist in hospitals and other health care facilities. (1)
- The most important approach to reducing the risk of occupational HIV transmission is to prevent exposure. However, in the event of occupational exposure, substance abuse treatment programs should follow the Center for Disease Control's recommendations for postexposure prophylaxis. (2)
- Rapid HIV tests are becoming readily available, and these tests will alter how and when HIV prevention counseling is delivered. Counselors must understand the technical aspects of these screening tests, as well as how to

assess each client's risk for infection. Reactive rapid tests must still be confirmed by a supplemental test (either Western blot or immunofluorescence assay). (2)

Integrating Treatment Services

- Treatment for substance abuse and HIV/AIDS should reflect the interconnected relationship they share and be coordinated as much as possible to maximize care for persons with both HIV/AIDS and substance abuse disorders. (2)
- Substance abuse treatment counselors and HIV/AIDS service providers should continue to develop their skills in establishing and maintaining treatment plans that support the "total" person. (2)
- In any effort to develop integrated treatment for substance abuse and HIV/AIDS treatment, either within a single agency or through individual care plans, the following are essential: having a strong case management model, including social services as a core part of the treatment plan, cross-training all providers in the requirements of the other treatment centers, and facilitating eligibility determinations. (2)
- Many HIV-infected substance abusers are unable to maintain abrupt and total discontinuation of substance use. In dealing with clients' ongoing substance abuse, treatment programs must find a balance between abstinence-oriented approaches, where clients must immediately stop substance use, or public health-oriented approaches, where clients who cannot abruptly abstain are encouraged to reduce substance use gradually. (2)
- Counselors who work with HIV-positive substance abusers should familiarize themselves with the local AIDS Service Organizations and substance abuse treatment services. (2)
- When establishing a network of care coordination, the provider must consider the issue of confidentiality. Providers must be aware of State and Federal laws and professional ethical codes, along with agency and community policies and agreements. The provider should understand the difference between "consent" and "informed consent." (2)

Accessing and Obtaining Needed Services

- A case management approach recognizes that satisfying such basic needs as general health and adequate housing and food when an individual is actively abusing substances can be overwhelming and that substance-abusing behavior will impair a person's ability to gain access to a formalized system of services. (2)
- The Panel recommends using case management in dealing with the multiple problems presented by HIV/AIDS in combination with substance abuse. Case management promotes teamwork among the various care providers. For example, linkages among the client's primary care provider, AIDS case manager, mental health provider, and substance abuse treatment provider can greatly benefit the client and improve care. (1)
- There are several procedures in multidisciplinary planning: determine who the significant providers are within the client's system; determine the nature of the group (i.e., fixed or ad hoc); discuss the expectations, rules, and structure of the group; establish formalized linkages with other agencies to

help build a group; if there are several case managers, designate one to act as "lead" case manager; and keep client confidentiality in mind. (2)
- To enhance effective teamwork, the multidisciplinary group should periodically assess itself to determine if there are any concerns or frustrations among its members. There also should be a periodic formal evaluation to allow members to review more thoroughly what is and what is not working. (2)
- It is sometimes difficult for the HIV-infected substance abuser to find and fund needed services. The case manager can play an important role in helping find specific services and navigate the plethora of public and private funding options. The counselor should be familiar with funding options for services such as substance abuse treatment, mental health treatment, medical and dental care, and HIV/AIDS drug therapy. (2)
- Counselors should be knowledgeable about the eligibility criteria, duration of service, and amount of assistance in their States for basic financial assistance programs, including welfare, unemployment insurance, disability income, food stamps, and vocational rehabilitation. (2)
- When faced with potential barriers to finding resources for clients, counselors should explore alternative resources, such as friends, significant others, and the community; other areas of the State; and client relocation to areas where services are available. (2)

Counseling Clients

- Before conducting any screening, assessment, or treatment planning, counselors should reassess their personal attitudes and experiences toward working with HIV-infected substance-abusing clients. It is important for a provider to reassess comfort level with each client because clients vary in demographic and cultural background. (2)
- Staff members must have the proper training to screen, assess, and counsel clients. The most important aspect of staff competency is that it is an ongoing process. (2)
- Providers should identify other programs and agencies with which to network in order to provide care for their clients. At a minimum, client services should include the following in order of priority: substance abuse treatment, medical care, housing, mental health care, nutritional care, dental care, ancillary services, and support systems. (2)
- Providers must take precautions when notifying clients of HIV test results, complying with regulations to ensure that their confidentiality is preserved. (2)
- Treatment providers and counselors must examine two essential factors when working with linguistically, culturally, racially, or ethnically different populations: the socioeconomic status of the client or group and the client's degree of acculturation. A distinction may need to be made between a population as a whole and a particular segment of that population. (2)
- Providers must work to develop culturally competent systems of care. One component of this involves making services accessible to and highly usable by the target risk populations. Effective systems also recognize the importance of culture, cross- cultural relationships, cultural differences, and the ability to meet culturally unique needs. (2)
- Clients facing progressive illness and disability need a variety of supportive services. The counseling of ill and dying clients should be supportive and

nonconfrontational, addressing issues relevant to the client's illness at a pace determined by the client. (2)

- Providers should increase their proficiency at counseling clients who are at the end stages of AIDS by examining their own beliefs about death and dying. (2)
- Providers should discuss end-of-life health care options with clients, such as making a living will, appointing a health care proxy, and so on, and they should do this before clients become ill. (2)
- In preparing their children for the loss of parents, clients should be practically assisted in the following areas: legal guardianship, standby guardianship, leaving a legacy of living memories, and dealing with survivor guilt. (2)

Ethical Issues

- Because providers routinely encounter emotionally charged issues when treating substance abusers, they should possess the tools to explore ethical dilemmas objectively. By doing so, and by examining their own reactions to the situation, providers can proceed with the most ethical course of action. (2)
- All programs should have a consistent process for dealing with ethical concerns. While ethical issues are usually complex enough to require a case-by-case evaluation, agency practices should include a routine process for approaching an ethical issue. (2)

Legal Issues

- Substance abuse treatment providers may encounter discrimination against their clients as they try to connect them with services. Counselors should be familiar with Federal and State laws that protect people with disabilities and how these laws apply to HIV-infected substance abusers. (2)
- Although the Federal law protecting information about clients in substance abuse treatment and State laws protecting HIV/AIDS-related information both permit a client to consent to a disclosure, the consent requirements are likely to differ. Therefore, when a provider contemplates making a disclosure of information about a client in substance abuse treatment who is living with HIV/AIDS, she must consider both Federal and State laws. (2)
- The rules regarding confidentiality in the provision of substance abuse treatment to persons with HIV/AIDS are very specific. Generally, no more than two sets of laws will apply in any given situation. If only substance abuse treatment information will be disclosed, a program is generally safe following the Federal rules. If HIV/AIDS-treatment-related information will be disclosed, and the disclosure will reveal that the client is in substance abuse treatment, the program must comply with both sets of laws (Federal and State). When in doubt, the best practice is to follow the more restrictive rules. (2)
- Any counselor or program considering warning someone of a client's HIV/AIDS status without the client's consent should carefully analyze whether there is, in fact, a duty to warn and whether it is possible to persuade the client to discharge this responsibility himself or consent to the program staff doing so. (2)

Funding and Policy Considerations

- At a minimum, treatment programs receiving funding for women's services must also provide or arrange for the following services for pregnant women and women with dependent children, including women who are trying to regain custody of their children: primary medical care, primary pediatric care (including immunizations), gender-specific substance abuse treatment, therapeutic interventions for children in custody of women in treatment, and sufficient case management and transportation. (1)
- States with a certain rate of AIDS cases must spend at least 5 percent of their total Substance Abuse Prevention and Treatment Block Grant funds on HIV/AIDS early intervention services for persons in substance abuse treatment. HIV/AIDS early intervention services are defined as appropriate pretest counseling for HIV/AIDS, testing services, and appropriate posttest counseling. All entities providing early intervention services for HIV disease to an individual must comply with payment provisions and restrictions on expenditure of grants. (1)
- Any organization that receives Substance Abuse Prevention and Treatment Block Grant funding for treatment services for injection drug users must actively encourage individuals in need of such treatment to undergo it. States require organizations to use outreach models that are scientifically sound, or, if no applicable models are available, to use an approach that can reasonably be expected to be an effective outreach method. (1)

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations are based on a combination of clinical experience and research-based evidence.

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Substance abuse treatment can play an important role in helping substance abusers reduce risk-taking behavior, thus helping to reduce the incidence of HIV/AIDS

Additional benefits include:

1. Increased access to care
2. Integrated treatment services
3. Increased adherence to treatment which can help prevent drug resistance
4. Decreased morbidity and mortality

Potential benefits of early initiation of antiretroviral therapy in asymptomatic HIV-infected clients include:

1. Control of viral replication and mutation, reduction of viral burden
2. Prevention of progressive immunodeficiency; potential maintenance or reconstitution of a normal immune system
3. Delayed progression to AIDS and prolongation of life
4. Decreased risk of selection of resistant virus
5. Decreased risk of certain drug toxicities (such as anemia)

POTENTIAL HARMS

- Adherence to antiretroviral treatment should be maintained because nonadherence can lead to the rapid development of drug resistance.
- Clients who are symptomatic with AIDS frequently are prescribed narcotic analgesics and may also have an indwelling intravenous line for infusion therapy. Injection drug users are at very high risk of using this indwelling intravenous line to administer heroin, cocaine, and other drugs of abuse. It is therefore essential that clients with such lines be cared for in residential settings where adequate monitoring and support can be provided.
- With highly active antiretroviral therapy the physician must be aware of potential drug interactions that can increase the toxicity of medications or reduce their levels in the patient's blood, resulting in suboptimal therapy and the development of resistance. The mental health counselor should be familiar with the symptoms that could indicate that a client is experiencing a drug interaction.
- HIV-infected individuals may be more sensitive to prescription medications as well as to drugs of abuse. When prescribing, clinicians should attempt to use the lowest effective dose to minimize side effects. With clients symptomatic with AIDS, it may be wise to begin with very low doses, of the magnitude generally associated with geriatric patients.
- Substance abusers are at increased risk of suicide. HIV-infected individuals may also be at risk of suicide, especially if they are suffering from a mood disorder. Medication should be dispensed in small amounts until a client's level of responsibility can be fully assessed. Prescribers should be aware that some medications such as tricyclic antidepressants (like amitriptyline [Elavil]) are especially likely to be lethal in overdose.
- The AIDS pandemic poses a number of challenges for infection control policy and practice in substance abuse treatment programs. Treatment programs should apply the same universal precautions that exist in hospitals and other health care facilities.
- The most important approach to reducing the risk of occupational HIV transmission is to prevent exposure. However, in the event of occupational exposure, substance abuse treatment programs should follow the Center for Disease Control's recommendations for postexposure prophylaxis.

Specific information about potential harms is listed in the original Treatment Improvement Protocol document, including the following:

- Figure 2-7: Interactions of HIV Medications with Street Drugs.

- Figure 2-8: Risks and Benefits of Early Initiation of Antiretroviral Therapy In the Asymptomatic HIV-Infected Client (lists common side effects with HIV medications)
- Figure 2-10: Summary of HIV Medications (lists common side effects with HIV medications)
- Figure 2-11: Summary of HIV Medication Schedules for Nucleoside Reverse Transcriptase Inhibitors, Nonnucleoside Reverse Transcriptase Inhibitors, and Protease Inhibitors (lists common side effects associated with HIV medications)
- Figure 2-12: Methadone Interactions With HIV Medications
- Figure 2-13: Prophylactic Regimens (lists side effects associated with prophylactic agents for pneumocystis carinii pneumonia, toxoplasmosis, and Mycobacterium avium complex)
- Figure 3-3: Use of Medications for Psychiatric Disorders in HIV-Infected Substance Abusers (lists side effects associated with medications used to treat psychiatric disorders in HIV-infected substance abusers)
- Figure 3-4: Abuse Potential of Common Psychiatric Medications

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- In light of the volumes of information available about HIV/AIDS, this guideline document is not intended to be exhaustive. A wide array of resources is provided for those who wish to find more information on topics of interest.
- Throughout this guideline document, the term "substance abuse" has been used in a general sense to cover both substance abuse and substance dependence (as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. [DSM-IV] [American Psychiatric Association, 1994]. Because the term "substance abuse" is commonly used by substance abuse treatment professionals to describe any excessive use of addictive substances, it will be used to denote both substance dependence and substance abuse. The term relates to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance abuse disorders as described by DSM-IV.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Treatment Improvement Protocols are distributed to facilities and individuals across the country.

The original Treatment Improvement Protocol document includes resources to help providers implement the recommendations in the Treatment Improvement Protocol.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Treatment Improvement Protocol (TIP) Series 37 Consensus Panel. Substance abuse treatment for persons with HIV/AIDS. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 2000. (Treatment improvement protocol (TIP) series; no. 37). [546 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2000

GUIDELINE DEVELOPER(S)

Substance Abuse and Mental Health Services Administration (U.S.) - Federal Government Agency [U.S.]

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GUIDELINE COMMITTEE

Treatment Improvement Protocol (TIP) Series 37 Consensus Panel

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available from the National Library of Medicine Health Services/Technology Assessment Text (HSTAT) Web site.

Print copies: Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Publications may be ordered from NCADI's Web site or by calling (800) 729-6686 (United States only).

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on December 18, 2000. It was verified by the guideline developer as of January 25, 2001.

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